PREMERA BLUE CROSS

Washington State Health Care Authority
Medicare Supplement Enrollment Form

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Applicant	Spouse
Social Security Number	Social Security Number
Applicant Last Name First Name Initial	**Spouse Last Name** First Name Initial
Mailing Address	Mailing Address
City State Zip	City State Zip
County / Phone Number	County / Phone Number
Date of Birth month day year / Sex ☐ Male ☐ Female	Date of Birth month day year / Sex ☐ Male ☐ Female
Medicare effective dates: Part A month day year / Part B month day year	Medicare effective dates: Part A month day year / Part B month day year
Medicare Claim Number (refer to your Medicare card)	Medicare Claim Number (refer to your Medicare card)

Medicare Supplement Plan desired ☐ Plan E ☐ Plan J

Please read the statements and answer the questions below.

A. You do not need more than one Medicare supplement contract.

B. If you purchase this coverage, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

C. If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement contract.

D. The benefits and premiums under your Medicare supplement contract can be suspended if requested during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your contract will be reinstituted if requested within 90 days of losing Medicaid eligibility.

E. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) and a "Specified Low-Income Medicare Beneficiary" (SLMB).

To the best of your knowledge,

1. Do you have another Medicare supplement policy or certificate in force? Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No
   a) If so, with which company? _____
   b) If so, do you intend to replace your current Medicare supplemental policy with this coverage?
   Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No
   (If you do not intend to replace all other Medicare supplement coverage, you are not eligible to apply for this program.)

2. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement coverage?
   Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No
   a) If so, with which company? _____
   b) What kind of policy? _____

3. Are you covered for medical assistance through the state Medicaid program:
   a) As a "Specified Low-income Medicare Beneficiary" (SLMB)? Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No
   b) As a "Qualified Medicare Beneficiary" (QMB)? Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No
   c) For other Medicaid medical benefits? Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No
   (If you are covered by Medicaid, you are not eligible to apply for this program.)

4. Did you receive a copy of the Outline of Coverage? ☐ Yes ☐ No

5. Would you like to receive a copy of the "Guide to Health Insurance for People with Medicare"? ☐ Yes ☐ No

I hereby apply for the Premera Blue Cross Group Medicare Supplement Plan, and agree to the terms of the contract offered. I understand that I must meet the applicable eligibility requirements, and apply within the time limits,that are shown on the back of this form. I hereby authorize the Social Security Administration to furnish to Premera Blue Cross medical or other information acquired by it under the Medicare Program to the extent necessary to process any claim under the contract in effect with Premera Blue Cross. This authorization is in effect for the duration of my coverage with Premera Blue Cross. I certify that the foregoing statements and answers are true, and I understand that all rights to payment of medical claims by Premera Blue Cross are void if any statement made by me herein is found to be false or incomplete.

Applicant	Spouse
X Sign the printed copy to authorize enrollment	X Sign the printed copy to authorize enrollment
Applicant Signature Date	Spouse Signature Date

65-8216(4-2002)
An Independent Licensee of the Blue Cross Blue Shield Association

Washington State Health Care Authority (HCA)
Plan E and J Eligibility Requirements

Public Employees Benefit Board (PEBB) and K-12 Retirees

To be eligible, you must be either an eligible PEBB or K-12 retiree or the eligible spouse of such a retiree. You must also be covered by Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare. Application must be made:

- In the 30-day period before you become eligible for Parts A and B of Medicare;
- Within 60 days of retirement;
- Within six months of initial enrollment in Medicare Part B;
- Within six months after attaining age 65; or
- During an open enrollment period, if any, established by HCA for PEBB and K-12 retirees, providing that you are enrolling from another health plan with no lapse in coverage.

Existing PEBB and K-1 2 subscribers may change their coverage by applying for another program offered by the HCA only at the HCA's next open enrollment period for PEBB and K-12 retirees.

All Other Applicants

To be eligible, you must be a current Washington State resident. You must also be covered by Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare.
Application must be made:

- Within 60 days of establishing Washington State residency;
- In the 30-day period before you become eligible for Parts A and B of Medicare;
- Within 60 days of retirement;
- Within six months of initial enrollment in Medicare Part B;
- Within six months after attaining age 65; or
- During an open enrollment period, if any, established by HCA for persons who are **not** PEBB or K-12 retirees, providing that you are enrolling from another health plan with no lapse in coverage.

Additional Application Periods for All Eligible Applicants

You can also apply for the HCA Plan E or J coverage if:

1. You left the HCA Plan E or J to try a Medicare+Choice program, PACE program, or Medicare Cost, Risk, or Select program for the first time. You may apply if you tried one program, more than one program of the same type, or more than one type of program. However, all four statements below must be true:

   - You were covered under each program you tried for less than 12 months
   - Each program (other than the most recent) must have been terminated involuntarily.
   - You switched programs within 63 days of the date the prior program terminated, with no other coverage inbetween.
   - The effective date of the last program you tried was less than 24 months after the effective date of the first program you tried.

2. If you are applying for the HCA Plan E or J offered only to people who have Medicare by reason of age, you can also apply if, at age 65 and first becoming eligible for Medicare Part A, you enrolled in one or more Medicare+Choice or PACE programs. All four statements in 1. must also be true.
   You must give us proof that you had and lost the coverage as described above. If you qualify for coverage under 1. or 2. above, you must apply no earlier than 60 days before your prior coverage is to end and no later than 63 days after that coverage ended. **Note: If you qualify under 1. above, you may only apply for the HCA Medicare supplement plan you had orginally.**